



APPLICATION FOR EXEMPTION FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT

EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENT

The Patient Protection and Affordable Care Act (ACA) added §5000A to the Internal Revenue Code (IRC) of 1986. Under §5000A, individuals meeting the following criteria are exempt from the penalty imposed for failing to maintain minimum essential coverage, and can apply for the exemption through Access Health CT.

	Exemption Type	Description
A	Religious Conscience	An individual who has an exemption under section 1311(d)(4)(H) of the ACA which certifies that he is or she is a member of a recognized religious sect or division described in section 1402(g)(1) of the IRC of 1986, and is adherent to the teachings of such a religious sect or division. In general, such religious sects/divisions include those that are opposed to acceptance of benefits or private or public health insurance. Such sect or division must have been in existence at all times since 12/31/1950
B	Membership in a Health Care Sharing Ministry	An individual who is a member of a health care sharing ministry as defined in section 501(c)(3) of the IRC and is exempt from taxation under section 501(a) of the IRC. Members of the health care sharing ministry must share a common set of beliefs and share medical expenses among members; members must retain membership even after they develop a medical condition; the ministry must have been in existence since 12/31/1999; and must conduct an annual audit by an independent certified public accounting firm.
C	Incarcerated Individuals	An individual who is incarcerated, not including those who are pending the disposition of charges.
D	Membership in an Indian Tribe	An individual who is a member of an Indian tribe, including any Alaska native village, that is recognized as eligible for the special programs and services provided by the United States to Indians.
E	Hardship (General)	An individual suffering a hardship with respect to the capability to obtain coverage under a qualified health plan. Hardship includes financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan.
F	Affordability based on Projected Income	Individuals applying for this exemption must first complete the application for health care coverage used to determine eligibility for advance payments of the premium tax credit. This exemption must be applied for during the open enrollment period for purchasing a qualified health plan.

To apply for an exemption, please print the Individual Exemption Application below, and follow the instructions on the application form.

An individual over age 30 wanting to purchase catastrophic coverage must receive a hardship exemption. Individuals age 30 and younger do not need an exemption to purchase this type of coverage.

In addition to the categories of exemptions above, there are several other categories of exemptions that individuals can apply for through the IRS. Information for applying for an individual exemption through the IRS can be found at www.irs.gov.



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Print and complete this form only if you are applying for an exemption from the healthcare coverage requirement.

Fields marked with an asterisk (*) are required. Please note that this is an "Individual" exemption application. A separate application must be completed for each family member applying for an exemption from the individual responsibility requirement.

Please Print

Applicant's Name*:		
Date of birth*: ____ / ____ / ____ Month Day Year If under 21 years old, parent or guardian's name: _____	SSN*: ____ / ____ / ____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	If this applicant will be a dependent on someone else's tax return, please provide the Tax Filer's Name and Social Security Number: Name _____ ____ / ____ / ____ Social Security Number
Current address*:		
City*:	State*:	ZIP Code*:
Mailing address (if different from current address above):		
City:	State:	ZIP Code:
Have you completed the Access Health CT application for health coverage? * <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is your Application ID (located in the upper right corner of your Eligibility Decision for Health care Coverage notice)? _____ What dates are you applying for the individual exemption? * From: ____ / ____ to: ____ / ____ Month Year Month Year		



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Check the type of exemption you are applying for? You may apply for more than 1 exemption category. Please include supporting documentation with your application.

A. Religious Conscience _____

B. Member of a Health Care Sharing Ministry _____

C. Incarceration _____

D. Member of a federally recognized Indian Tribe _____

E. Hardship (General) (Please describe in detail and include any supporting documentation:

(Attach additional paper if necessary)

F. Affordability based on Projected Income _____

To apply for this exemption, you must complete the general application for health care coverage on Access Health CT and provide the determination notice as documentation)

I am signing this application under penalty of perjury. I have provided true answers to all the questions on this form to the best of my knowledge.

Signature of Applicant or Guardian of Applicant

Date

Please send completed application and any supporting documentation to:

**Access Health CT
P. O. Box 670
Manchester, CT 06045-0670**

Please allow 90 days for Access Health CT to respond.
If you have not received a response after 90 days, please call Access Health CT at 860-757-5300